Indonesia is the largest archipelagic nation in the world and the fourth most populous country. The country’s health system is facing the double-burden of communicable and noncommunicable diseases, which is also straining its young national health insurance scheme, Jaminan Kesehatan Nasional (JKN), started in 2014. SP4PHC works with the Ministry of Health (MOH) to support reforms that strengthen strategic purchasing, with a focus on family planning (FP) and maternal, newborn and child health (MNCH). Below are general health financing statistics to better understand current health expenditure (CHE), sources of revenue, and out-of-pocket (OOP) expenditure.

OOP health expenditure in Indonesia has followed regional trends, as it has greatly decreased in the last 20 years. However, over 34% of CHE is still comprised of OOP payments even though over 84% of Indonesians are covered by JKN.

**CHE by Source of Revenue (2018)**

- National Insurance Contributions: 13.2%
- Other Domestic: 47.6%
- National Government Transfers: 36.1%
- Government Foreign: 0.2%
- Voluntary Prepayment: 2.7%
- Direct Foreign: 0.2%
- Other Ministries: 2.1%
- National Insurance: 31.9%
- Sub National: 24.1%
- Private Health: 14.5%
- Household OOP: 31.9%

**Indonesia’s Health Expenditure by Purchaser (2018)**

- Ministry of Health: 4.5%
- Other Ministries: 2.1%
- Sub National: 24.1%
- National Insurance: 31.9%
- Private Health: 14.5%
- Household OOP: 31.9%

**Trends in OOP Expenditure as a Percentage of CHE in Indonesia**

OOP health expenditure in Indonesia has followed regional trends, as it has greatly decreased in the last 20 years. However, over 34% of CHE is still comprised of OOP payments even though over 84% of Indonesians are covered by JKN.
As countries such as Indonesia implement strategies to achieve universal health coverage (UHC), they are undertaking health financing reforms to mobilize more financing for health and ensure that available funds for health are used optimally and equitably. Strategic purchasing is linked to the second objective. Making purchasing strategic involves basing purchasing decisions on information about provider behavior and population health needs. However, most countries have multiple purchasers and purchasing schemes and these reforms are often overlaid on existing systems, risking further fragmentation and mixed signals to health providers.

Under SP4PHC, ThinkWell is working with individual purchasers critical for the delivery of PHC, especially family planning (FP) and maternal, newborn and child health (MNCH) services and assisting governments to improve coherence between purchasing arrangements at the system-level. The figure below shows the fragmentation in Indonesian health spending, with OOPs remaining stubbornly high even as social health insurance (JKN) spending grows.
Funding for the health sector in Indonesia is fragmented. Law No.22/1999 gave subnational governments (especially at the district level) greater autonomy in raising and allocating budgets. As such, funds from the national government mostly go to BPJS-K (the implementing agency for JKN), but there are also allocations for MOH-managed hospitals, subnational government transfers (i.e., for salaries), and priority health programs. Subnational governments must allocate at least 10% of their annual budgets to pay for health, which can include service delivery for key priority programs, certain public facilities, and subsidies for the poor to access JKN. The funds that go into BPJS-K are then spent through a variety of provider payment mechanisms, including case-based group, monthly capitation, and fee-for-service payments to public and private providers. Notably, PHC facilities are supposed to serve as gatekeepers to more expensive levels of care.

Note: BPJS-K = Badan Penyelenggara Jaminan Sosial – Kesehatan (Social Insurance Administering Body for Health). BPJS-K manages JKN.

PBI = Members who are listed as poor and vulnerable and their coverage is subsidized by the government
CBG = Case-based groups are set reimbursement rates for health services
DAU = General funds that are allocated by the national government to subnational governments
DAK = Earmarked funds allocated by the national government to subnational governments specifically to support disadvantaged districts provide public programs, with priority given to national health programs

PHC facilities are gatekeepers. In other words, in order to access secondary or tertiary care, you generally need to be referred to by a PHC provider first.
The national and district authorities, as well as JKN, purchase health services in different ways. Historically, these purchasers have not aligned well with one another, leading to fragmentation and inefficiencies in the health financing landscape. National level programming and sub-national financing of health care still play a substantial role in purchasing in Indonesia, even with the introduction of JKN. Still, the JKN scheme allows the most flexibility and opportunity (with its purchaser-provider split) to institute strategic purchasing mechanisms that can effectively respond to the diverse health needs and challenges the archipelago presents. These mechanisms are still being finetuned, as JKN is only 7 years old.

<table>
<thead>
<tr>
<th>Purchaser attributes</th>
<th>National Government</th>
<th>Sub-national Government</th>
<th>National Health Insurance (JKN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of revenue (e.g., taxes, premiums)</td>
<td>National taxes, loans, and grants</td>
<td>Provincial- and district-level governments can collect separate taxes (e.g., cigarettes and fees (e.g., business licenses))</td>
<td>Tax subsidy for targeted populations and general taxes</td>
</tr>
<tr>
<td></td>
<td>General public</td>
<td>General public in sub-national areas</td>
<td>Monthly contributions for waged workers at 5% of wages, split between employer and employee</td>
</tr>
<tr>
<td></td>
<td>Promotive and preventive programs, TB, Malaria, and HIV; operational fund for primary health care (PHC) and hospital; special fund allocation for facility infrastructure at subnational level</td>
<td>Services offered depend on variable sub-national fiscal capacity and commitment; promotive and preventive program, etc.; operational funds for public PHC facilities and hospitals</td>
<td>Monthly contributions for non-waged/informal workers a flat rate ranging from IDR 42,000 – 150,000</td>
</tr>
<tr>
<td></td>
<td>Only public PHC facilities and public referral hospitals; automatic contracting</td>
<td>Mostly public PHC facilities and public referral hospitals; sub-national governments can contract with private providers</td>
<td>Formal and informal sector covered after contributions; poor are automatically covered without contribution</td>
</tr>
<tr>
<td></td>
<td>Line-item budget for infrastructures, operations; National Population and Family Planning Board buys the FP commodities and distributes subnational to public healthcare facilities</td>
<td>Line-item budget for salaries, operations, etc.; Sub-national authority buys additional FP commodities, distributes to public facilities</td>
<td>FP services (counseling &amp; methods), ANC, deliveries, c-sections, postnatal care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PHC facilities and referral hospitals (public and private); nearly 60% contracted are private providers, via selective contracting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Capitation to PHC facilities: IDR 3000-6000 per member per month for Puskesmas, IDR 4000-10,000 for private PHC. Accounts for bulk of revenue for Puskesmas, though most are unable to use all revenue from capitation mainly due to lack of guidance. Those with BLUD status have more autonomy to use funds.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-capitation rates (quasi-fee-for-service) to PHC facilities for FP and MNCH services; case-based groups for referral hospitals</td>
</tr>
</tbody>
</table>
While JKN coverage is rapidly growing, there is growing concern about the financing sustainability of the scheme with consistently rising costs. Since 2016, JKN has been running a deficit which has caused the Government of Indonesia to consider health financing reforms to ensure continuing coverage without sacrificing the UHC goals of financial protection and equitable access to quality health services.

**Membership, Cost, and Revenue for JKN (2014-2019)**

*Source: BPJS-K 2019*

- While JKN coverage is rising, the scheme still struggles to enroll the large informal sector in Indonesia. Those of the informal sector that are covered by JKN, are much likelier to be poor and part of the subsidized JKN PBI membership group.

**Percentage Coverage of Formal and Informal Workers, by Insurance Type**

*Source: Susenas (Indonesia National Socioeconomic) 2019*
This figure shows JKN coverage at the district level, broken down by membership type. It is sorted by the proportion of covered members that are poor – from left to right, districts with more poor enrolled to districts with less. PBI generally constitutes a majority of JKN members, especially in the less developed provinces towards the East of the country. The rise in coverage, especially for subsidized vulnerable populations, contributes to the rise in costs to the government. This has implications for the sustainability of JKN.
JKN contracts with a wide range of public and private providers. Nearly half of all PHC facilities are public (Puskesmas), whereas private clinics and general practitioners (GPs)/midwives also play a substantial role (48%). At the hospital level, nearly two-thirds are private with publicly-funded regional and central hospitals making up the remaining. While these rapidly growing private hospitals often contract with JKN, private PHC facilities and GPs/midwives often do not join JKN due to several reasons, including low payment rates and burdensome administrative processes.

**PHC Facilities Contracted with JKN, by Type (2019)**
*Source: BPJS-K 2019*

- Public PHC: 43%
- Private PHC: 23%
- Public hospital: 2%
- Private hospital: 3%
- Private GP/Midwife: 5%
- Other providers: <1%

**Referral Hospitals Contracted with JKN, by Type (2019)**
*Source: BPJS-K 2019*

- Public PHC: 63%
- Private PHC: 29%
- Public hospital: 8%
- Private hospital: 8%
- Private GP/Midwife: 5%
- Other providers: <1%

**Facilities Contracting with JKN, Broken Down by Province**
*Source: Risfaskes 2019*

Western, more urban provinces have higher supply-side readiness scores, driven by more availability of private sector providers. Eastern provinces have lower readiness scores, as they are largely made of public PHC facilities and very few private providers.
JKN spending is largely at the higher, more costly hospital levels and not at the cheaper, PHC level. So, while many Indonesians are increasingly using PHC services (like the last figure shows), most of the costs are at the referral level (as the 1st figure shows). The large costs of JKN are of great concern to the Government of Indonesia and they are actively exploring reforms to the scheme to ensure its sustainability.

### Proportion of Costs of Health Care in JKN Program, by Source (2016-2018) in IDR Million

<table>
<thead>
<tr>
<th>Year</th>
<th>PHC Outpatient</th>
<th>PHC Inpatient</th>
<th>Hospital Outpatient</th>
<th>Hospital Inpatient</th>
<th>Promotive &amp; Preventive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>55.7%</td>
<td>1.1%</td>
<td>24.6%</td>
<td>18.3%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>55.7%</td>
<td>1.1%</td>
<td>27.9%</td>
<td>15.1%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>54.9%</td>
<td>1.2%</td>
<td>29.0%</td>
<td>14.6%</td>
<td></td>
</tr>
</tbody>
</table>

### JKN Spending at PHC Level by Provider Type – Via Capitation, IDR Billion (2018)

- To Public PHC (Puskesmas) **9,499**
- To Private Clinics **2,627**
- To Private GP/Dentists **1,075**
- To Other PHC facilities **7**

### JKN Spending at Referral Level by Service Type – Via Claims, IDR Billion (2018)

- Outpatient Services **27,384**
- Inpatient Services **51,780**

### Utilization of Health Services (2014-2019) in IDR Million

- Visit to PHC facility
- Visit to outpatient clinic/hospital
- Cases of hospital inpatient

<table>
<thead>
<tr>
<th>Year</th>
<th>Visit to PHC facility</th>
<th>Visit to outpatient clinic/hospital</th>
<th>Cases of hospital inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>66.8</td>
<td>21.3</td>
<td>3.7</td>
</tr>
<tr>
<td>2015</td>
<td>100.6</td>
<td>4.2</td>
<td>6.3</td>
</tr>
<tr>
<td>2016</td>
<td>120.9</td>
<td>6.3</td>
<td>7.6</td>
</tr>
<tr>
<td>2017</td>
<td>150.3</td>
<td>49.3</td>
<td>8.7</td>
</tr>
<tr>
<td>2018</td>
<td>147.4</td>
<td>64.4</td>
<td>76.8</td>
</tr>
<tr>
<td>2019</td>
<td>180.4</td>
<td>94.7</td>
<td>94.7</td>
</tr>
</tbody>
</table>
JKN and OOP Payments

Even if JKN now covers over 84% of the population, 34% of CHE is still comprised of regressive OOP spending. The first figure shows how OOP is evenly split between medicines, curative, and preventative healthcare. Most medicines are non-prescription drugs, often acquired at local shops and pharmacies. The majority of OOP spending on curative care is at private PHC facilities and midwives, often where JKN does not provide coverage. Most of OOP spending on preventative care is on contraceptive methods like injectables and pills.

OOP Components in 2019
Source: Indonesia National Socioeconomic Survey 2018 and 2019

In a study conducted by the SP4PHC team, we found that households with JKN coverage experienced statistically significantly less OOP payments (-39%) when accessing health care than the uninsured. The study also found that JKN has a pro-poor effect, as those in quintile 1 (poorest) and 2 (poor) had a significantly higher probability to obtain health care without spending any OOP, compared to the uninsured. The effect was larger among the poorer quintiles than the wealthier ones, though not by a large amount.